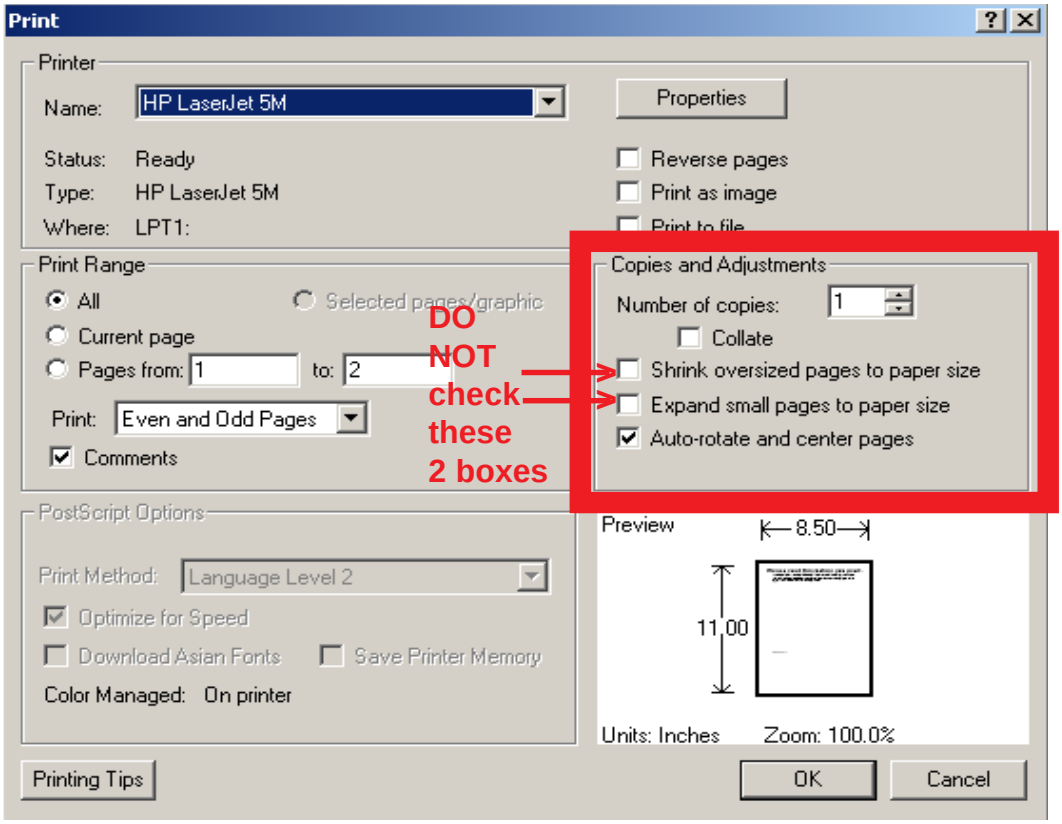
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



DOH 600-033 (2/2004)

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Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Podiatric Medicine and Surgery Inactive License Reactivation Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.

* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Podiatric Physician and Surgeon (Inactive) DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 665-016 (2/2004)

1F 0252010000 00357

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE NUMBER	DATE

LICENSE #

Application For Inactive Podiatric Medicine And Surgery Credential Activation

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Supporting documents should be filed with the Health Professions Quality Assurance Division at least sixty (60) days before license is needed. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee. Make remittance payable to the Department of Health.

All applications must be accompanied by applicable fees (fees are nonrefundable). For applicable fee, please see instructions. Mail remittance payable to Department of Health, Revenue Section.

NOTE: The mailing address you provide will be listed on your license and all correspondence from the Department will be sent to this address until you notify us of a change.

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
( )	( )	— —

GENDER	BIRTHDATE (MO/DAY/YR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male	/ /	

HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR

MEDICAL SPECIALTY

PODIATRIC SCHOOL	YEAR GRADUATED

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

2. Education and Training

Provide a chronological listing of your educational preparation and post-graduate training. Attach additional 8 1/2 x 11 sheets if necessary.

SCHOOLS ATTENDED	NUMBER OF YEARS ATTENDED	DATES OF ATTENDANCE FROM (MO/YR)	DATES OF ATTENDANCE TO (MO/YR)
PODIATRIC MEDICAL EDUCATION			
RESIDENCY PROGRAM (IF APPLICABLE)			

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ..... ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ..... ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ..... ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ..... ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ..... ☐ ☐

   b. a charge of a sex offense? ..... ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ..... ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ..... ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ..... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ..... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ..... ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

4. Professional Experience

In chronological order list all professional experience received since graduation from your podiatric medical school to the present. Exclude activities listed under other sections. (Attach additional 8 1/2 x 11 sheets if necessary.)

NAME OF EXPERIENCE OR PRACTICE AND LOCATION	ATTENDANCE	
	FROM (mo/yr)	FROM (mo/yr)

5. Hospital Privileges

List hospitals and locations where privileges have been granted within the past five (5) years. (Attach additional 8 1/2 x 11 sheets if necessary.)

NAME OF HOSPITAL AND LOCATION	DATES	
	FROM (mo/yr)	TO (mo/yr)

6. Previous Licensure

List all licenses granted with type, date, grantor, and if license is active or inactive. (Attach additional 8 1/2 x 11 sheets if necessary.)

STATE OR OTHER	PROFESSION	CERTIFICATE		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YEAR	NUMBER		EXAMINATION	OTHER	
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No

7. AIDS Education and Training Attestation

I certify I have completed the minimum of 7 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

8. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Application Instructions For Inactive Podiatric Physician and Surgeon Credential Activation

Attached is the abbreviated application packet for reactivation of your expire Washington State Credential. When your application for expired credential activation is received by the Department of Health, Podiatric Medical Board, you will be sent an acknowledgment letter noting receipt, and any outstanding documentation needed to complete the process.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ Pay $850.00 in total fees. **(All fees are non-refundable)** This includes the $825 Current Renewal Fee and $25 Substance Abuse Monitoring Fee.
- ☐ ***Box #1 Demographic Information.***

  Name: Please list your current name with middle initial.

  Residential Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

  Telephone Number: Enter current telephone number where you may be reached during normal business hours.

  Social Security Number: Required for license by 42 USC 666 and Chapter 26.23 RCW.

  Additional Data: This information is required to update the Department's database, and confirm information from your previous (initial) application.
- ☐ ***Box #2 Education and Training.*** Required to update the Department's database.
- ☐ ***Box #3 Personal Data Questions.*** Required by WAC 246-12-040. This section pertains to formal or informal disciplinary action by any regulatory authorities, hospitals, state or federal jurisdictions, criminal convictions and civil judgments connected with the practice of podiatric medicine. If you are answer "yes" to any question, please provide a synopsis of the situation, as well as the appropriate supporting documentation.
- ☐ ***Box #4 Professional Experience.*** In chronological order, list all professional work experience since your Washington State credential has expired. Please identify all time breaks of 30 days or more. If you need additional space, attach on a separate piece of paper.
- ☐ ***Box #5 Hospital Privileges.*** Please list in Section #5 those hospitals where privileges have been granted in the past five years.
- ☐ ***Box #6 Previous Licensure.*** List **all** credentials you have held since last being credentialed in Washington State. List in chronological order, most current first. Include your last active credential in Washington State. If you need additional space, attach on a separate piece of paper.
- ☐ ***Box #7 AIDs Education and Training Attestation.*** Required by WAC 246-12-040 and 246-922-070.
- ☐ ***Box #8 Applicant's Attestation.*** Required to be signed and dated in order to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Additional Documentation Required For Activation:

☐ ***Continuing Education Attestation.*** Required by WAC 246-12-040 and 246-922-300. Include copies of certificates of attendance for the most recent two years documenting at least 50 hours approved continuing education.

☐ ***Professional Liability Action History.*** Malpractice information pertaining to any civil suit or judgment in connection with the practice of a health care profession. Include the nature of the case, date and summary of the care given, and settlement amount. The applicant must provide a separate summary of each case, and include copies of the settlement or final disposition. If pending, indicate status. If the case is rather old, you should be able to contact the county where it was filed to get the documentation. *Please attach on a separate piece of paper.*

☐ ***State Licensure Verification.*** Applicants must verify all podiatric medical licenses that he or she holds, or has held, in any other state, territory or possession of the United States or Canadian province since the expiration date of your previous Washington State credential. Verification is required whether the license is active or inactive. This includes temporary and training licenses. Applicants should contact the state licensing authority for information regarding fees for verification of licensure. *Form provided.*

☐ ***Hospital Privileges .*** Applicants must verify all hospitals where admitting or specialty privileges have been granted in the last five (5) years. Verification must be received directly from the hospital. All hospital privileges connected with military practice experiences may be verified by the current duty station or, if no longer in active service, the appropriate agency of record or National Personnel Records Center, (Military Personnel Records), 9700 Page Boulevard, St. Louis, MO 63132. *Form provided.*

☐ ***Federation of Podiatric Medical Boards Data Bank Clearance.*** The Board requires verification of any disciplinary actions directly from the Federation. Disciplinary reports are $40.00 per report and may be obtained from the Federation, P.O. Box 740525, Boynton Beach, FL 33474-0525, (561) 477-3060. *Form provided.*

The process of reactivation will involve retrieval of your previous credential file from the state records center. The retrieval time period is approximately two (2) weeks.

Once the abbreviated application is considered complete, it will be referred for review. All information, document, data, etc., provided to the Department by the applicant is to be submitted in writing and will become part of the file. Telephone information will not be accepted in place of written documentation. The Department may conduct additional investigation of irregular information contained in the file or documentation by contacting primary sources or other agencies as necessary to verify application information. Primary source documentation must be original. FAXed documents will not be accepted.

Applications and fees are to be sent to:

Department of Health
Podiatric Medical Board
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries and documents should be directed to:

Department of Health
Podiatric Medical Board
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4943

Washington State Department of Health
Podiatric Medical Board
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4943

Hospital Investigative Letter

NAME OF APPLICANT (Please Print) _____ BIRTHDATE (MONTH/DAY/YEAR) _____

I have applied for a license to practice Podiatric medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my hospital privileges and return it directly to:

Department of Health
Podiatric Medical Board
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4943

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Podiatric Medical Board.

SIGNATURE OF APPLICANT _____ DATE _____

I. Does the applicant, currently or has the applicant ever had any practice privileges at your hospital? ☐ Yes ☐ No

Beginning Date _____ Ending Date _____

2. Has the applicant's privileges ever been restricted, suspended or revoked by the medical staff office or administration? ☐ Yes ☐ No

If yes, explain _____

3. Has the applicant ever been asked to resign or surrender any privileges voluntarily in lieu of action being taken? ☐ Yes ☐ No

If yes, explain _____

4. Is there any information in your files that could call into question the applicant's ability to safely practice podiatric medicine and surgery? ☐ Yes ☐ No

If yes, explain _____

Name _____

Title _____

Facility _____

Address _____

_____

Telephone Number _____

Authorized Signature _____

Date _____

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Washington State Department of Health
Podiatric Medical Board
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4943

State Licensure Investigative Letter

NAME OF APPLICANT (Please Print) _____ BIRTHDATE (MONTH/DAY/YEAR) _____

I have applied for a license to practice Podiatric medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my state licensure and return it directly to:

Department of Health
Podiatric Medical Board
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4943

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Podiatric Medical Board.

SIGNATURE OF APPLICANT _____ DATE _____

To assist the Washington State Board in evaluating the above physician's application, we would appreciate receiving the following information.

License Number _____ Date license was issued _____

Status of License: ☐ Active ☐ Military ☐ Other _____
☐ Inactive ☐ Expired

Has the applicant's license ever been suspended or revoked? ☐ Yes ☐ No

Has any other disciplinary or corrective active been taken? ☐ Yes ☐ No

Has the licensee surrendered the license in lieu of disciplinary action? ☐ Yes ☐ No

If you have answered Yes to any of the questions above, attach supporting documentation pertaining to disciplinary orders or any other actions.

State Board _____

Address _____

_____

Telephone Number _____

State Seal

Authorized Signature _____

Date _____

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
P.O. Box 47869 • Olympia, Washington 98504-7869

Podiatric Medical Board

Request For Physician Disciplinary Profile/PMLexis Score Report

This form is to be completed by the Podiatric physician and surgeon and mailed directly to the following along with a $40 fee for Disciplinary Reports plus $35 fee for PMLexis Score Reports (**exam candidates do not need to request scores)**:

Federation of Podiatric Medical Boards
PO Box 740525
Boynton Beach, FL 33474-0525
(561) 477-3060

Please Print or Type

Full Name: _____
FIRST MIDDLE LAST

Address: _____
STREET CITY STATE ZIP

Date of Birth: _____ Place of Birth: _____

Podiatric Medical School: _____

Date of Graduation: _____ Social Security Number: _____

PMLexis Information: State taken: _____ Date taken: _____

_____ _____
APPLICANT SIGNATURE DATE

Federation of Podiatric Medical Boards—Please return information to the following State Agency:

Department of Health
Podiatric Medical Board
PO Box 47869
Olympia, WA 98504-7869
(360) 236-4943

Federation Stamp